Kleinschmidt (C.H.A.)

A CASE

OF

PROLAPSUS UTERI

COMPLICATING LABOR

BY

C. H. A. KLEINSCHMIDT, M.D.,

WASHINGTON, D.C.
Professor of Physiology in the Medical Department of the University of Georgetown.

Reprinted from THE AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN, Vol. XVIII., *January*, 1885.

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It goes without saying that in no other branch of applied medicine is the practitioner so frequently confronted by the least expected complications, and thrown so much upon his own resources, as he is in obstetrics. Called to a case of labor, especially in a primipara, or in one he has never attended in labor before; or where some ignorant midwife has through neglect or mismanagement converted a perhaps normal labor into a difficult one; or, where she, failing to correctly appreciate the conditions obtaining and finally, being caught in the lurch, sends for the physician to take charge of an all but hopeless case; or if, as in the case about to be reported, the service is rendered in the country, miles from home and without ready access to advice, and, of course, without any of the modern aids and appliances found in the well-regulated homes of the city; in all these and other instances

readily recalled in the experience of every obstetrician, the "what to do, and how to do, and when" stands forth with greater force and dimension than in the routine life of the physician. And, to still add to the difficulty, there is, in the vast majority of instances, no chance to consult authorities, to read up the case; for while the obstetrician may indeed try to beguile the tedious hours of waiting by the perusal of a magazine or journal, he may not, and for very good reasons, study a treatise on obstetrics while attending a case of labor. It is our duty, therefore, to present the history of any case in practice, which shows features, either in its course or treatment, or in both, not conforming to the usual run of ordinary cases; and more especially does it become a duty, when the text-books do not devote an adequate attention to some of these complications, especially as to their management. The case about to be reported is one which presented itself to me as almost new in practice, and certainly new in the method adopted for preserving the lives of both mother and child. It is, as indicated, a case of prolapse, occurring at an early period of gestation and continuing up to labor at term. Some years ago I met with a case somewhat similar, *i. e.*, there was also prolapsus during labor, but no special other difficulty in delivery, and besides, as I had not the management of the case, only coming in at the last moment, it left no special impression on my mind, and its history has been well-nigh obliterated from memory.

The case which forms the basis of the present paper, however, was seen and attended by the reporter, at least throughout the period of labor and the lying-in state, while the previous history was obtained through the kindness of Dr. G. Gilpin, of Tenleytown, supplemented by some data of which I had personal knowledge.

History:—Some six years ago, a young man called on me to treat him for what he feared, and correctly so, to be the symptoms of secondary syphilis. He admitted that he had had a sore on the penis, following some time after suspicious sexual intercourse. Had also had swelling of the inguinal glands, but no suppurating bubo. From the evidence presented at his first visit, which it is needless to recapitulate, he was placed on specific treatment, which was continued for some months. From the first visit to the last, he always expressed a desire to know how long it would

be before he would be entirely cured, and finally he admitted that he was engaged to be married, and desired to tie the hymeneal knot as soon as possible. He also asked my advice with regard to his fiancée, who, he said, had been suffering from a sore upon her lower lip, for some time, for which she had been treated by a practitioner of the homeopathic school, but which thus far had resisted treatment. He had offered to bring her to my office for examination, but she had persistently refused because of want of faith in what she and her family were pleased to call "allopathic" medicines. I then advised that he, if possible, put her upon the same medicine prescribed for himself and watch the effect. He did so, and finally the sore healed. After that he succeeded in presenting her to me in what appeared to be perfect health. She looked like a mere child, very short in stature, a pronounced blonde, of plump build, with the very face of a baby. Her health, she said, was excellent; had never been better, and her looks did not contradict her words. I still, however, advised him privately, as I had done before, against marriage, but inasmuch as the symptoms of syphilis had been subdued, he finally concluded, in direct opposition to my expressed opinion of the probable consequences of such a step, to take the risks and get married, and, of course, did so. I lost sight of the parties for some years, they having become residents of Tenleytown, Dr. Gilpin being their family physician. I have been thus far perhaps too tedious in my details, but the syphilitic taint undoubtedly existing may perhaps have had some connection with the subsequent trouble. From notes furnished by Dr. Gilpin, I now trace the history after marriage. She is at present twenty-four years old, has been married five years, and her first child, male, was born in October, 1882, after a tedious labor, during which there occurred a slight rupture of the perineum which was overlooked. Her general health during gestation had been good up to the seventh month, after which she complained of severe pains in the back and hips. There was also some uterine hemorrhage during the eighth month. The child soon developed symptoms of what was supposed to be infantile syphilis, and was treated accordingly, and with good result. She became again pregnant about the middle of April, 1883. On June 7th, 1883, Dr. Gilpin was called in and found her suffering from bearing-down pains, a sensation of weight about the hips, and severe pain in the back. Examination revealed a prolapsed uterus, projecting from the vulva about one inch when the patient was in the erect position, but receding when the recumbent position was assumed. There was at this time some bleeding from the uterus, which continued at intervals of from one to three weeks, during the entire course of pregnancy, and suggested placenta previa, or a partially detached placenta. On June 7th, she was supposed to be about six weeks pregnant. Upon a second examination, made about the 10th of July, the cervix was found inflamed and swollen, and in August it began to assume a spongy appearance, while

the pain in back and hips greatly increased. During the month of September there was more or less bleeding continually, especially during the last weeks, ushered in by excessive pain for a day or two before the hemorrhage. This hemorrhage appeared mostly in clots, and its appearance seemed to relieve the pain, which was always slight during the flow. During October there was scarcely any bleeding, while there were occasional slight hemorrhages during November and December, and once in January, about one week before delivery. After the middle of the sixth month, the recumbent posture did not reduce the extruded organ, the prolapse becoming permanent; some relief being afforded by a bandage, worn diaper fashion together with an abdominal bandage. The general condition of the woman, from the time of first descent of the womb to that of labor at term, a period of about seven months, was variable. The appetite was poor as a rule; she was most of the time weak, and required the use of tonics. She had frequent and severe headaches, with flushed face, and complained of cold feet. The latter at times were greatly edematous; hence she could take but little exercise. It appears from these notes of Dr. Gilpin, that, beyond the bandages referred to, little was done in the way of local appliances or applications to keep the protruding organ within the vaginal canal, and the patient told me afterward that, although weak, she still tried to go about as much as possible, and resisted any efforts at local treatment. Indeed one of the most striking features of the case, as obtained from her own lips, was that she was able to visit in the country, and actually in the sixth or seventh month attended a ball given several miles up the country. The constant exposure of the cervix, together with the friction, to which it must have necessarily been subjected, readily accounts for the condition of things when I first saw her, and when labor actually set in. Another point in this connection is, that in spite of the numerous hemorrhages, in spite of the exposure of the uterus, she did not abort, although no special pains were taken on her part to prevent such an accident.

I now come to that portion of the history of the case in which I was personally concerned. On Sunday, January 6th, 1884, Dr. Gilpin sent her husband for me, with a message to come up, as he thought labor had set in; or if not, that it should be induced to check a severe hemorrhage then occurring. Arriving at the house about three-quarters of an hour after receiving the message, I found the patient pacing the floor, every now and then grasping the foot of the bedstead, stooping over, and in short showing the familiar action of a woman in the first stage of labor. She was placed in bed for the purpose of examination, when the following was revealed to my, I cannot deny it, astonished gaze. For although Dr. Gilpin had, upon a previous occasion, incidentally spoken of the case, I had no idea as to the extent and condition of the protruded part. The following was what I found: A protrusion filling the vulva completely, and extending be-

yond it for no less than from two to three inches.' This was the cervix, and neither the bladder nor the vagina had any part in the procidentia, as has occurred in a number of the recorded cases. The cervical walls were greatly thickened, measuring at least one inch. The tissues felt more solid than normal, and especially in the anterior lip were of an almost cartilaginous, or perhaps more correctly, connective-tissue hardness and consistence. The surface, especially at the sides and in the rear, felt roughened and all parts showed very little sensibility. The protrusion had the form of a truncated cone, with its base at the vulva, measuring at least three inches in diameter, its apex between the thighs, and about one inch less in diameter. The external os was open and readily admitted the points of two fingers, which passing inward, disclosed the internal os also open, and the fetal head presenting. The vertex was resting immediately in the rear of the vulva, and by gently pulling apart the walls of the cervix could readily be seen. Had it not been for the conditions in front, one would have thought that it was just about to clear the perineum. Further investigation soon proved that she was not in labor; that the pains of which she complained were not the result of uterine contraction as discovered by placing the hand upon the abdomen and grasping the organ. I now became anxious to discover whether the uterus was fixed in this abnormal position, or whether it could be replaced. This because I deemed it best, in the event of labor setting in, to conduct it in as normal a manner as possible. Mere pushing against the protruding part, with the woman in the recumbent position, had no perceptible effect, although I presume that more vigorous efforts on my part might perhaps have succeeded; but I feared lest greater force applied might do mischief. The patient was now directed to assume the knee and shoulder position, which she did, when the uterus suddenly, and with a perceptible jerk, if I may say so, was replaced by its own weight into the abdominal cavity. The cervix in this position could be felt about two inches from the ostium vaginæ. As soon as the recumbent position was resumed, however, the descent at once began, and in a few minutes was as complete as ever; the movements of the diaphragm evidently aiding the abdominal muscles in forcing the organ down. Inasmuch as the experiment just related had not been without considerable pain to the woman, I did not care to repeat it, but suggested that the protruding mass be enveloped in absorbent cotton, impregnated with carbolized oil. As to the source of the hemorrhage, I could discover nothing, there was no sign of it when I arrived, it having ceased some time before, and a careful examination found no proof of a partial placenta previa, the head alone being the presenting part. Nor was there anywhere within reach that peculiar softness or pulpiness of the uterus itself accessible to the touch, which is said to be, and I believe correctly so, characteristic of the site at which the placenta is attached. Before leaving the house, after assuring her and her family that she

was not in labor, I suggested that she be kept as quiet as possible, and that some opiate be given when occasion required, relief from pains evidently not those of parturition. This was my re-introduction to the patient, and it will readily be admitted that the prospect of attending a case of this kind, miles from those whose counsel and aid could be invoked in case of need, was far from cheering. Therefore, while revolving in my mind what might be the probable and possible outcome, what the emergency and how to meet it if called upon, I hoped that I would escape the responsibility, and as I heard no more of the patient for a week, I concluded that the case had terminated favorably and without trouble, like one that had occurred in Dr. Gilpin's practice some months previous to this, in which the child was born without special trouble, although there was prolapsus. In this case, however, the uterus descended either during or else immediately before labor. As the sequel shows, this hope was very soon to be dissipated, for at about 10 P.M., January 15th, 1884, I received an urgent message to come at once and attend the patient. Taking the short forceps and a pocket case of instruments, I soon was on the way in a severe snow storm, arriving at the place about 11 o'clock P.M. Dr. Gilpin had not reached the house, but was momentarily expected. I found labor in full progress, the pains recurring about every ten minutes, every pain forcing the uterus down upon the vulva, the internal os protruding slightly beyond, with the uterine segment inclosing the head of the child distending the perineum. Os opened to the extent of about one and one-half inches, liquor amnii had been discharged some time before my arrival, and the head could readily be felt, and its contours mapped out by the exploring finger, which showed that it presented in the occipito-posterior position, the vertical prominence with every pain producing a decided bulging in the centre and to both sides of the perineum, which latter, however, was at this time by no means put upon the stretch. In fact, I may state right here, that this structure at no time of the labor was subjected to a degree of stretching endangering its integrity.

Dr. Gilpin arriving soon after, the patient was put in bed, and efforts made to reduce the prolapse, not only in the intervals, but also during the pains. The former object was readily accomplished by manipulation and directing the cervix uteri and head of the child against the sacrum, but as soon as the uterine contractions would set in, the same protrusion recurred unless checked by decidedly forcible pressure of the head. It was evident, therefore, that nothing was to be gained by this method. Matters thus continued until about 1 o'clock A.M., the pains becoming more and more vigorous, yet making no impression upon the diameter of the cervical canal, at least as regards dilatation, while there was a gradual shortening until finally the head of the child presented less than one-half inch within the external os. I had again and again, by sweeping the well-oiled finger around the edges of the os, endeavored to assist in the

dilatation, but without effect. The tissues were hard and unyielding, and the condition is perhaps best illustrated by saying that while the neck, or rather its canal, was readily movable over the presenting head, it walls could not be stretched apart by any force short of causing rupture. Thus if, just before a pain came on the uterus was replaced, the os could be moved either forward or backward over the child's head, a uterine contraction would then, in the former case, cause a bulging of the posterior portion of the neck and lower segment of the uterus, filling the vulva from the fourchette forward, the head being exposed beneath the pubic arch; while in the latter case, the anterior portions of neck and uterus would fill the vulva from before backward, the head appearing in a sort of a triangle formed by the fourchette and the anterior portion of the lip. Thus, while the os could be shifted *in toto*, it could not be made to dilate with all the vigor of uterine contraction, and, what is of interest, the *neck* was never entirely obliterated, even to the very last, although toward the end it had greatly shortened from its former length, by at least two inches. It had become evident by this time that Nature was entirely inadequate to effect delivery, and I therefore decided to apply that friend in need, the forceps. If you will picture to the mind's eye the condition of things, the vertex projecting beyond the vulva with every pain, the patulous os surrounded by the thick rim of the cervix, you will conclude that the application of the forceps, provided the head was, as in this case, of normal, if not subnormal dimensions, should have been readily accomplished. And this proved to be the case. There was no need to guide the blades upon the fingers; the eye readily discovered the place for introduction, and both blades were thus quickly applied and as quickly locked. The neck now grasped the blades of the instrument about two inches above the handles, and, say, three-quarters of an inch from the angle of the blades. This, I think, will give an idea as to the size of the os at this time. Waiting for a pain, which was not long in coming, I made traction in the direction of the pelvic axis, with the object of sweeping the head over the perineum, but the cervix, greatly to my disgust, did not yield, and instead of the fetal head alone, the uterus, slowly but surely, descended. Dr. Gilpin now applied the palms of his hands, grasping the descending uterus, and endeavoring to keep it back, while traction was again applied by the forceps. But there was not the least yielding of the rigid cervical walls, and an ominous, though slight, noise of tearing fibre admonished me to desist from further efforts in this direction; indeed, I am certain that, while delivery might have been effected by forceps, it would have been at the expense of rupture of the cervix—a rupture either single or multiple, which might or might not involve the body of the uterus. This conclusion once reached, the forceps were removed, and the question arose, What next? There were but three methods to be considered. 1. To give Nature another chance by waiting for her to overcome the obstacles to delivery. 2. To

lessen the presenting part by craniotomy. 3. To enlarge the os by incising the neck. It did not require a lengthy consultation for the adoption of the method last named, the others being thrown out for reasons to be given further on. It being decided then to attempt delivery by incising the cervix, the patient's husband was dispatched to town to get a can of ether, there being none in Dr. Gilpin's armamentarium medicum, and I, in my hurry to get to the scene of action through a driving snowstorm, having neglected to fortify myself with it. This was about 2 A.M., and an hour was allowed for the return of the husband with the anesthetic. This hour, from 2 to 3 in the morning, was about the most uncomfortable I have ever spent, and in an occasional country practice, chiefly devoted to bad cases of obstetrics and surgery, extending over the period of some eighteen years, some very uncomfortable hours have been encountered, but this hour of suspense seemed more weighty and endless than any of them. The pains, sharp, quick, and vigorous, followed each other in rapid succession without making the least impression upon the progress of the child and the delivery. The cervix appeared as if made of unyielding cartilage, the os opening just so much and no more, and with each pain I felt sure that the walls of the uterus would give way, for the expulsive efforts were of the kind so aptly termed heroic by a gentleman whom I once assisted in a forceps delivery. And, one pain happily over without the dreaded rupture, there was the suspense as to what the next would bring forth, until I more than once was tempted to proceed with the operation determined upon, and would have done so had not the woman strenuously objected to undergo "being cut to pieces," as she was pleased to call it, without ether. At last, just about 3 A.M., the husband returned, and we at once prepared for the operation by giving a drachm of the fluid ext. of ergot previous to the administration of the anesthetic. This was done as a possible prophylactic to a hemorrhage and to insure a prompt uterine contraction after delivery of the child and the secundines. She readily went under the influence of the anesthetic, and we proceeded as follows: The forceps having been introduced and locked without difficulty, as before, Dr. Gilpin made gentle but steady traction until the fetal head had reached the most advanced position, beyond which it could not be carried by anything short of a force sure to lead to rupture of the neck of the uterus; here it was maintained by the instrument in the hands of Dr. Gilpin. This maneuvre had the other effect of putting the anterior and posterior lips upon the stretch, that is, upon what limited degree of stretching they would admit of. The most prominent part of the head was now slightly in advance of the fourchette, and had passed the perineum, the lips of the os encircling the blades of the forceps being about one-half inch in front. The hairy scalp of the child was in plain view between the shanks of the instrument, thanks to the somewhat uncertain light afforded by an oil lamp held in the hands of the

only female attendant. The anterior lip was of a glistening aspect, and felt to the finger like an aponeurosis, or a tendon, perfectly smooth, and to the eye appeared of a whitish or rather bluish-white color. The obstacle to the passage of the head seemed to be a firm ring encircling the cervical canal just at the point to which the former had advanced, aided by the forceps. I now introduced a sharp-pointed curved bistoury, guided by two fingers of the left hand, into the cervical canal to the distance of about one inch, and, piercing the anterior wall of the neck, cut from within out and above downward, slitting the lip longitudinally. The knife, in its passage through the callous tissue, which looked very much like old cicatricial tissue, caused a creaking sound, plainly audible to Dr. Gilpin and myself. This incision, I hoped, would increase the space sufficiently to permit the passage of the head; but as soon as traction was made, it was discovered that the area thus gained was insufficient. I then slit the posterior wall to about the same extent, but even this was not sufficient, and as in applying traction the anterior walls gave signs of being ready to give way, I preferred a clean cut to a probable tearing, and extended the incision to the point of union between vagina and uterus. After this, there was no further trouble, and the child was delivered promptly. The hemorrhage following the incisions was comparatively slight, much less so than I had expected, and was readily subdued by pressure. A small artery spouting from the wound of the anterior lip, however, had to be controlled by torsion. The child was still-born, but was readily resuscitated after a few minutes. While I attended to the child, Dr. Gilpin removed the placenta without any difficulty, and the uterus contracted as promptly and as firmly as after an ordinary labor. We now thoroughly washed out the uterus, an easy task in this case, with a solution of carbolic acid, and applied sutures to bring the cut edges of the anterior and posterior walls, respectively, together. Two stitches were taken in each, one uniting the cut surfaces at the circumference of the os, the other between this point and the terminus of the incision. These were quite sufficient to secure perfect apposition. The only material at hand for this purpose was silk, and I have no doubt, had silver wire been used, there would, quite likely, have been union by first intention after this primary trachelorrhaphy. The sutures having been cut off short and the parts thoroughly cleansed by carbolized water, the uterus was now gently replaced within the vagina, and a ball of carbolized absorbent cotton, filling the canal below, was introduced to serve as a sort of extemporaneous pessary. The patient had by this time recovered from the anesthetic, and expressed her gratitude in no measured terms at the successful termination of her troubles. She was directed to keep perfectly quiet, and in the recumbent position; to have a dose of morphia, if needed, to check pain or restlessness, and some beef tea if she desired any food.

I left the patient about 5 A.M., in excellent spirits and condi-

tion. Saw her again at 2 P.M. of the same day, January 16th Her face was somewhat flushed, but she felt very comfortable. There was no hemorrhage, the cotton plug being barely stained. Not having had an action of the bladder, I suggested to Dr. Gilpin that her urine be drawn off by catheter if the bladder should fail to act before night; temp. 100°, pulse 80; no tenderness over abdomen. January 17th, 2 P.M., pulse 110, temp. 100°; face still flushed; slight tympanites, but no pain. The bladder had acted sufficiently and freely. Had slept well during the night, although the after-pains had troubled her considerably yesterday. Removing the cotton plug, the uterus was found to have retained its position within the vagina. Washed out vagina with carbolized water and re-inserted plug of carbolized absorbent cotton. Without the advice of her physician, she had during the morning taken a large dose of castor-oil, which had not as yet operated. January 18th, 2 P.M.—The castor-oil had operated three or four times, producing loose, copious stools which had considerably prostrated her. For this reason, Dr. Gilpin had given a full dose of laudanum in the morning, and she now expressed herself as feeling very comfortable. Had slept from 9 P.M. to 6 A.M.; had no pain; abdomen flat; no pain produced by pressure applied to it. All trace of tympanites had disappeared. Had had beef-tea until she was tired of it, and loudly clamored for a broiled steak, which was allowed. Urine voided without difficulty or pain, and in sufficient quantity. Removed plug of cotton, which gave no odor. She peremptorily refused an examination of the sutures. The lochia were perfectly normal, and unmixed with pus; vagina again washed out with carbolized water; temp. 100.4°, pulse anywhere between 80 and 120. This great variation in the pulse, which appeared up to nearly the last visit made by me, was, I have good reason to believe, a mere matter of nervousness, for while Dr. Gilpin would tell me that at his morning visit the pulse was normal, it would at once begin to fluctuate with a decided upward tendency as soon as she heard of my arrival, hence I from this time on took little or no heed of this feature, and confined my attention to and derived conclusions from her general condition and temperature. Thus I find at the end of my notes of this day, that she is doing well thus far. Left off cotton plug and simply dressed the outside with a wad of cotton. January 19th, 2 P.M.—Temp. 100°, no attention to pulse; patient bright and cheerful, yet nervous and greatly frightened at the thought of an examination through the speculum; hence this was not insisted on, but digital examination proved that the cervix was softer than before, and without excessive rise in temperature; abdomen still more reduced; lacteal secretion has been established, and she nurses her baby regularly. Suggested quin. sulph., gr. x. night and morning.

January 20th, 2 P.M.—Temp. 100.4°; patient exceptionally bright, submitted to examination by the speculum, which revealed very little if any swelling of the cervix; sutures in situ; there was

some discharge of a somewhat putrid odor, but no tenderness over the abdomen. Had slept soundly all night; bowels not moved, but appetite good; decidedly nervous on account of the examination; to continue the quinine and use the carbolic acid injections twice a day. All the bed clothing, etc., to be changed. January 21st, 2 P.M.—Temp. 99.6°, not quite so nervous; has slept all night, no pain anywhere. The cloths upon the outside of the vulva barely stained; passed cotton wad, saturated with carbolized lotion, into the vagina; it was withdrawn without being stained, and free from odor of a putrid character. She greatly desires more solid food and a greater variety; allowed oysters to be added to her dietary; doing well. January 22d, 2 P.M.—Temp. 99.6°; quinia has been kept up, removed sutures, which was readily accomplished; union imperfect, but there is very little discharge; os presents very near the vulva. Suggested carbolized cotton wad, to be introduced twice daily, and vagina to be cleansed thoroughly after every removal. Has had a dose of castor-oil (having refused an enema), and bowels had been moved. Spirits excellent; talks about getting up and attending to her room, because she is ashamed to lie in bed, as she says, like a sick woman. Did not see her on the 23d, but saw her mother-in-law, who was her nurse, who informed me that she had been somewhat excited after I left, but had passed an excellent night, and was bright and cheerful now. Dr. Gilpin sent down the following record of her temperature: January 23d, 9 A.M., 98.4°; 8 P.M., 98.4°; January 24th, 11 A.M., normal. I paid my last visit January 25th, when all went on as well as could be. At this visit I advised her and her husband to have trachelorrhaphy performed at some future time, but have not heard from them as yet.

This is the record of a case of complicated labor which it was my good, or if you will, bad fortune to attend, and I now beg indulgence upon some points of interest. In the first place, it is remarkable, although by no means unique, that a pregnant uterus should appear, in part at least, outside the vulva at so early a period of pregnancy, and remain in this position with greater or lesser constancy, without leading to an abortion, the woman going to full term. I say the fact is remarkable, though not isolated, for in looking over the literature of the subject, it is simply astonishing to meet with the comparatively large number of cases of labor complicated by prolapsus, in some of them the entire uterus being outside of the vagina, and lying between the thighs in the form of an immense tumor. A striking feature of the case was the comparatively little trouble this prolapse gave to the patient during pregnancy. True, she was

complaining of pains in back and loins, but became by no means bedridden, as is attested by her telling me that she attended a dance some miles up the country without minding it, as she said. Then again, what produced the frequently repeated hemorrhages? Was this menstruation continued through pregnancy, as was observed in one of the recorded cases? Or was there a partially detached placenta? There certainly was no condition of placenta previa, partial or complete, and according to Dr. Gilpin, who delivered the afterbirth, the placenta was attached on the right side of the uterus near the fundus.

And this persistent hemorrhage makes it all the more astonishing that abortion did not take place, even in the absence of any measures calculated to prevent such an accident. The chief factor, I take it, in the production of the prolapse, over and above a relaxed condition of the uterine ligaments, was an unusually large and wide pelvis. The woman was indeed small of stature, as I said, a mere child, but her hips were extraordinarily wide and her pelvic cavity roomy beyond the normal. That this was the case is proven by the easy descent of the uterus surrounding the head of the child, which latter (the child) was of average size, weighing about eight pounds. The amplitude of the external soft parts was illustrated by the fact, stated before, that the perineum was not put upon the stretch at any time sufficiently to endanger its continuity.

Now, as to the question of treatment, three methods presented themselves for consideration. 1. The policy of waiting upon Nature, supported by the time-honored dictum that "meddlesome midwifery is bad." It is hardly worth while to discuss this point. True, we might have waited, for the patient's strength was by no means exhausted, and labor had continued for a few hours only, but what would have been the result? Either rupture of the uterus, death of the child, or operative interference with the woman in a condition much less calculated to bear the shock. I therefore believe that, after failure of artificial dilatation of the os short of incision, and after the ineffectual application of the forceps, the only duty before us was to relieve the woman, for it was evident that the powers of nature were not equal to the task of forcing the child through the rigid-walled canal, or had they finally

succeeded, would have done so at the expense of fearful, and perhaps fatal laceration. Hence, delay in this and similar cases would, in my humble opinion, be equal to criminal neglect. The second proposition discussed was craniotomy. This, I also submit, would have been out of the question under the circumstances. Here was a living child, proved to be so by the subjective symptoms supplied by the mother, who felt its movements, and by the objective ones of the fetal heart-beat and the tense feel of the scalp, so unlike the corrugated and flaccid condition presented by the dead fetus. Craniotomy, then, would have resulted in the certain death of the child, and in, no doubt, extensive injuries to the soft parts of the mother, endangering her life; it, therefore, was simply discussed to be rejected. There then remained, as a means of speedy delivery, incision of the indurated structures to an extent sufficient to permit of delivery by forceps. With the fact before us, that lacerations of the cervix, even in natural labor, are by no means rare, and with the other fact, that trachelorrhaphy, either primary or secondary, readily restores the parts to the *status quo ante*, it need not be wondered at that the last-named method was selected as the proper one in this case. Its advantages may be summed up briefly as follows: the injury is comparatively slight and readily repaired by art. It is still more slight, nay trifling, compared with the beneficial results derived from it; it saves mother and child, and substitutes a clean cut surface for the ragged edges of a cervix lacerated by the fetal head, thus lessening, if not altogether doing away with, the danger of septic poisoning. It is easily and readily done without complicated instruments, without a host of assistants. It is the operation dictated by common sense as applied to medicine and surgery, and may readily be performed at any place. In this case it was done by the aid of a common oil-lamp to guide the sight of the operator.

In conclusion, I desire to express my thanks to Dr. Gilpin for the promptness with which he entered into my intentions and for the able and loyal assistance and support rendered during the operation and the subsequent management of the case.